DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 1 — 0 1 5

2. STATE: Indiana

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: July 1, 2001

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
1905(a)(27) of the Act

7. FEDERAL BUDGET IMPACT:
a. FFY 2001 $ 0
b. FFY 2002 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1-A, Page 9

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 3.1-A, Page 9

10. SUBJECT OF AMENDMENT:
Religious Nonmedical Health Care Institutions

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Kathleen D. Gifford

13. TYPED NAME:
Kathleen D. Gifford

14. TITLE:
Assistant Secretary, OMPP

15. DATE SUBMITTED:
9/13/01

16. RETURN TO:
Kathleen D. Gifford
Assistant Secretary
Office of Medicaid Policy & Planning
402 W. Washington, Room W382
Indianapolis, IN 46204
ATTN: T. Brunner, Plan Coordinator

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
9/17/01

18. DATE APPROVED:
10/30/01

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
7/1/01

20. SIGNATURE OF REGIONAL OFFICIAL:
Cheryl A. Harris

21. TYPED NAME:
Cheryl A. Harris

22. TITLE:
Associate Regional Administrator
Division of Medicaid and Children's Health

23. REMARKS:

RECEIVED
SEP 17 2001
DMCH - IL/IN/OH

FORM HCFA-179 (07-92)

Instructions on Back

State/Territory: Indiana

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND
REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.

/X/ Provided: /__/ No limitations /X/ With limitations*

/__/ Not provided.

b. Services provided in Religious Nonmedical Health Care Institutions.

/X/ Provided: /__/ No limitations /X/ With limitations*

/__/ Not provided.

c. Reserved

d. Nursing facility services for patients under 21 years of age.

/X/ Provided: /__/ No limitations /X/ With limitations*

/__/ Not provided.

e. Emergency hospital services.

/X/ Provided: /X/ No limitations /__/ With limitations*

/__/ Not provided.

f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.

/__/ Provided: /__/ No limitations /__/ With limitations*

/X/ Not provided.

* Description provided on attachment